Primary Insurance Information

Client Name: _____Birth Date: _____/_____/_____

Gender given to insurance company: _____

Insurance Company: _____

Phone #: _____ Address: _____

City: _____ State: _____ Zip: _____

I.D. # _____ Group # _____

POLICY HOLDER PERSONAL INFORMATION

Name: _____

Relationship to Client: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Birth Date: _____/_____/_____ Gender given to insurance co: _____

Work Phone:_____ Other Phone:_____

Employer: _____

Billing Information

Who is responsible for payment for this patient? Self/Patient: _____ Other: _____

Responsible Person: _____

Please complete the following information if different from policy holder information given above:

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Birth Date: _____/_____/_____

Marital Statue: Single_____ Married_____ Other _____

Employer: _____ School (school name, part time/full time): _____

Verbal Permission to share information with my billing service: Yes No Date of Initial Appointment: _____
Date of Telephone Call: _____